COVENTRY
Health Care of Delaware, Inc.

Dependent Coordination Of Benefits Questionnaire

A. Please enter your Member ID Number: _____

B. Do any of your dependent children have other health care coverage? Please check one:

_____ No If no, please check this line, sign this form at the bottom, and return it to the address at the bottom of this form.

_____ Yes. If yes, please fill out Sections C and D, then sign this form at the bottom, and return it to the address at the bottom of this form.

C. Please fill out this section concerning your dependent children's other coverage:

_____ Another Coventry Health Care of Delaware contract. I.D. Number: _____

_____ Another HEALTH insurer:

Name of the other health insurance company: _____

Name of policyholder: _____ Birthdate: _____

Name of employer: _____

Address where claims are submitted: _____

Effective date of policy: _____/_____/_____; if cancelled, date: _____/_____/_____

Names of those covered:

_____	_____	_____
Dependent Child	Dependent Child	Dependent Child
_____	_____	_____
Dependent Child	Dependent Child	Dependent Child

D. Does the other coverage as shown in Section C include a prescription drug program? ___ Yes ___ No

Name of drug plan: _____

Thank you for your for completing this questionnaire. The information you have provided will help us process your claims.

Your Signature: _____ Daytime Telephone Number: _____

Your Name (please print): _____